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Commentary

Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights?

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A B S T R A C T

The International Conference on Population and Development in Cairo in 1994 laid out a bold, clear, and comprehensive definition of reproductive health and called for nations to meet the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. In the context of the ongoing review of the International Conference on Population and Development Programme of Action and the considerations for a post-2015 development agenda, this article summarizes the findings of the articles presented in this volume and identifies key challenges and critical answers that need to be tackled in addressing adolescent sexual and reproductive health and rights. The key recommendations are to link the provision of sexuality education and sexual and reproductive health (SRH) services; build awareness, acceptance, and support for youth-friendly SRH education and services; address gender inequality in terms of beliefs, attitudes, and norms; and target the early adolescent period (10–14 years). The many knowledge gaps, however, point to the pressing need for further research on how to best design effective adolescent SRH intervention packages and how best to deliver them.

The concepts of sexual and reproductive health (SRH) and of reproductive rights were adopted for the first time by governments under the aegis of the United Nations at the International Conference on Population and Development (ICPD) in Cairo in 1994. ICPD laid out a bold, clear, and comprehensive definition of reproductive health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" [1]. The ICPD Programme of Action (PoA) was forward looking in many areas of SRH and rights and notably in relation to adolescents and young people. It called for "meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality." It also stressed that reproductive health services should be made accessible through primary health care systems to individuals of all appropriate ages, including adolescents, as soon as possible and no later than the year 2015 [1]. At the ICPD and its 5-year review in 1999, governments recognized that investing in the health of adolescents is important not only for the well-being of adolescents but also for the current and future well-being of

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communities and societies. Confirming the critical importance of adolescent sexual and reproductive health and rights (ASRHR), the Commission on Population and Development in 2012 issued some of the strongest language on the reproductive rights of young people to emerge from a global intergovernmental negotiation. Key points of the final resolution included the right of young people to comprehensive sexuality education (CSE), to decide on all matters related to their sexuality; access to SRH services, including safe abortion where legal, that respect confidentiality and do not discriminate; and the protection and promotion of young people's right to control their sexuality free from violence, discrimination, and coercion [2].

In 2014, the international health and development community is reviewing 20 years of progress made in implementing the ICPD PoA, and in 2015, a new set of sustainable development goals will be established for a post-2015 development agenda. New global agendas will be set, which will shape funding decisions and country programs for several years. There are calls by some stakeholders for a stand-alone goal on adolescents and youth in the post-2015 agenda, whereas the General Assembly's Open Working Group on Sustainable Development Goals, among others, has indicated that youth concerns need to be reflected across goals. There are also strong calls for adolescents and young people to take an active part in shaping and monitoring this agenda. This article reviews what progress has been made in addressing ASRHR as defined by the ICPD PoA and provides important ways forward given the upcoming Sustainable Development Goals 2030.

Rationale for addressing adolescent sexual and reproductive health and rights

While adolescents generally enjoy good health compared with other age groups, they face particular health risks, which may be detrimental not only for their immediate future but for the rest of their lives. Estimates and data clearly show that adolescent ill health and death constitute a large portion of the global burden of disease and, therefore, need special attention. The health of adolescent girls and particularly their SRH is of particular concern for a number of reasons:

1. Adolescents account for 23% of the overall burden of disease (disability-adjusted life years) because of pregnancy and childbirth [3]. An estimated 16 million births annually occur to young women aged 15–19 years, representing 11% of all births [4]. Almost all (95%) of adolescent births take place in developing countries and 18% and 50% of births annually in Latin America and sub-Saharan Africa, respectively, occur during adolescence [5]. Approximately 2.5 million births occur to girls aged 12–15 years in low-resource countries each year of which around a million births occur to girls younger than 16 years in Africa [6].
2. Early childbearing is linked with higher maternal mortality and morbidity rates [7–9] and increased risk of induced, mostly illegal and unsafe, abortions [10]. Maternal causes constitute the leading cause of death among adolescent females [3,11]. An analysis of data from 14 countries in Latin America for the period 1985–2003 found that girls aged under 16 years have four times higher risk of dying in pregnancy or childbirth than women aged 20–24 years [12]. Adolescent pregnancy is independently associated with increased risks of low birth weight, preterm delivery, severe neonatal conditions, and early neonatal death (because of the increased risk of preterm birth) [9].
3. Of the estimated 22 million unsafe abortions that occur every year, 15% occur among young women aged 15–19 years and 26% occur in those aged 20–24 years [13].
4. Gender-based violence is an all too common reality for many adolescents, especially girls. Globally, an estimated 30% of adolescent girls (15–19 years) experience intimate partner violence according to recent World Health Organization estimates [14]. Violence against women and girls increases the risk of adverse SRH outcomes including unintended pregnancy, acquisition of HIV and other sexually transmitted infections (STIs), as well as other adverse health outcomes such as the harmful use of alcohol and mental health disorders (e.g., depression) [15–17].
5. Female Genital Mutilation/Cutting (FGM/C) is a significant and widespread problem. According to recent estimates, about 125 million girls and women living in 27 African countries, Yemen, and Iran have been subjected to this harmful traditional practice [18]. An estimated 3.3 million girls are at risk of undergoing FGM/C in Africa alone every year [19].
6. An estimated one million young people aged 15–24 years are infected with HIV every year representing 41% of all new infections among those aged 15 years and older [20]. Globally, young women make up more than 60% of all young people living with HIV; in sub-Saharan Africa, the corresponding number is as high as 72% [15].

The previously mentioned data highlight the widespread and serious nature of SRH problems faced by adolescents, especially girls. There continues, however, to be significant limitations in the indicators used to gather information on the state of ASRHR [5]. Even when data are gathered, it is often not age or sex disaggregated, and thus, particular vulnerabilities and issues are sometimes hidden [21]. Nonetheless, the significant amounts of data we have are sufficient to assess where we are today, 20 years after the ICPD.

There are strong public health, human rights, and economic reasons to invest in adolescent SRH. Promoting mutually respectful attitudes between and among adolescent girls and boys in connection with sexuality as well as other healthy behaviors (e.g., reducing the harmful use of alcohol and other substances) will form the foundation for the good health of populations as adolescents become adults and for social and economic development more broadly. Investing in the health of adolescents in general can help prevent the estimated 1.4 million deaths that occur globally every year because of road traffic injuries, violence, suicide, HIV, and pregnancy-related causes in this age group. It can also improve the health and well-being of many millions of adolescents who experience health problems such as depression or anemia [22].

There is also growing recognition of the economic benefits of investing in the healthy development of adolescents and the economic costs of not doing so. Adolescents represent one fifth of the global population; healthy competent adolescents who enter the workforce can raise the economic productivity of a country. Economists stress the importance of using this "demographic dividend" to reap the benefits of having a growing cohort of working age adults relative to the dependent population for national development. However, this requires an investment in human and physical capital that enables adolescents and young people to stay healthy, get educated, and find productive and income-generating employment [23,24]. On the other hand, not

investing in the health and development of adolescents contributes to the vicious cycle of ill health and socioeconomic deprivation. For example, girls from poor communities are more likely than those in more well-to-do communities to become pregnant during their adolescence. This in turn leads to a loss of educational and employment opportunities, keeping them and their children in poverty.

Determinants of adolescent sexual and reproductive health

A complex set of factors contribute to SRH problems in adolescents and especially in adolescent girls. Worldwide, boys and girls are reaching puberty earlier and are marrying later than their parents did. Contextual factors, such as the pressure to conform to media stereotypes and the norms of their peers as well as impaired judgment resulting from the use of alcohol and other psychoactive substances, make adolescents more likely to expose themselves to risks. Many adolescents become sexually active at an early age when they do not know how to avoid STIs and unwanted pregnancies. At an individual level, because girls' bodies are still growing and developing, pregnancies in early adolescence are associated with greater risk of obstructed labor, and young girls are, by virtue of their biology, more at risk of contracting HIV and possibly other STIs.

Because of gender-based discrimination, girls are in many settings less likely than boys to get an education, the health care they need, and the opportunity to grow and develop before taking on adult roles. In many parts of the world, gender norms dictate that girls should marry and begin childbearing in their early or middle teenage years, well before they are physically or mentally ready to do so. Early marriage exposes them to a range of risks including high-risk pregnancies and births, intimate partner violence, and the transmission of HIV [25]. In many settings, adolescent girls have less power to negotiate safe sex with their partners, especially if they are in relationships with older men, and these relationships involve the exchange of sex for money or favors under economic duress.

Violence also starts early in the lives of many girls. In some cases, the perpetrators are strangers. In most other cases, they are peers or influential adults within—or in close contact with—their families. This makes it harder for girls to refuse unwanted sex or to resist coerced sex. Gender norms not only make such violence acceptable in society but force women and girls to bear this burden in silence by blaming and stigmatizing them. The practice of FGM/C, which has been recognized internationally as form of violence against women, can cause severe complications during childbirth, make sexual intercourse painful, and can be a vector for infection, including HIV infection. It also deprives women of the potential for a "satisfying sex life," a component of reproductive health recognized by the ICPD PoA.

Some adolescents may be further marginalized because of individual characteristics (such as disability or sexual orientation), family characteristics (such as a single-parent household or alcohol abuse by one parent), community characteristics (such as ethnicity) or societal characteristics (such as poverty, homelessness, civil strife, and war). Marginalized adolescents are more likely to experience health and social problems and less likely to obtain preventive and curative health services. There is little solid evidence as to how to best address these factors [26].

Adolescents' vulnerability to poor SRH is compounded by the lack of availability of, and access to, youth-friendly services and health products as well as by adolescents' insufficient, inaccurate, or complete lack of knowledge and information about safe sex and contraceptive use. For example, many adolescents have neither the economic or practical means to obtain the health commodities (such as condoms and other contraceptives) they need to protect themselves or to access the health services they need to return to good health should they contract a disease (e.g., an STI). In many countries, CSE is still not widely available in schools. These realities have a negative impact not only on the health and development of girls and boys but also affect nations in their efforts to reach their development goals [25].

Almost all countries are parties to the Convention on the Rights of the Child, which guarantees the right of all children, including adolescents, to obtain the health information and services they need to survive and grow and develop to their fullest individual potential [27]. This is especially true for those adolescents who are more likely to develop health problems because social, economic, and cultural factors increase their vulnerability.

Reviewing the evidence, the progress made, and gaps in addressing adolescent sexual and reproductive health and rights since the International Conference on Population and Development Programme of Action

On February 4–6, 2013 World Health Organization, in partnership with the International Women's Health Coalition and the United Nations Population Fund, organized an Expert Group Meeting to review the current evidence on ASRHR; examine the progress made in policies and programs in the 20 years since the ICPD; and discuss and identify implications for implementing the ICPD PoA beyond 2014 and for the post-2015 agenda.

Five articles were commissioned to inform the discussions at the Expert Group Meeting. These articles form the basis of the articles that have been included in this special issue focused on ASRHR. The themes selected cover five complementary and inter-related intervention areas to promote ASRHR. Each article presents an overview of the evidence on promising and effective interventions, the progress made, gaps and challenges, and implications for policies, programs, and research. The five themes are

1. Creating an enabling environment for ASRHR: What do we know about what works?
2. Providing CSE: emerging trends in evidence and practice.
3. Providing adolescents SRH services and increasing adolescent demand and community support for their provision: What works?
4. Addressing intimate partner and sexual violence among adolescents: emerging evidence of effectiveness.
5. Ensuring youth's right to participation and the promotion of youth leadership in the development of SRH policies and programs.

In the first article, Svanemyr et al. [28] apply an ecological framework to outline the key elements of creating an enabling environment for ASRHR. The ecological framework highlights the importance of interventions at the individual level to strengthen agency and facilitate empowerment of adolescents; at the relationship level to promote supportive relationships with partners, parents, and peers; at the community level to change social norms that enable adolescents to learn about their sexuality, access services, and challenge harmful practices; and at the

societal level (policies, laws, and media campaigns) to create both state and institutional accountability and create broader structural change in support of adolescent sexual and reproductive health (ASRH). The article highlights that to create an enabling environment for ASRH; one needs to implement programs and projects with multiple components that operate at multiple levels of the ecological framework. The field of developing and evaluating such multicomponent and multilevel programs is an emerging one; the review identified few rigorous evaluations.

The second article underscores the importance of CSE to the ASRHR agenda [29]. Haberland and Rogow review the evidence on the effectiveness of CSE on ASRHR. Their review reiterates the broad scientific agreement that sexuality education does not foster earlier sexual debut or unsafe sexual activity. In terms of concrete results, most programs, which have been well designed and well delivered, show reductions in self-reported risk behavior, but not all of them show corresponding decreases in negative health outcomes such as unintended pregnancies or STIs. A growing number of projects place gender equality and human rights at the heart of the CSE curriculum and use interactive and participatory methods to foster critical thinking. These projects reach adolescents and young people both in and out of school. Emerging evidence suggests that CSE programs that include content on gender equality, power relations, and human rights and use participatory methods are more likely to show positive SRH outcomes for adolescents than those that do not. The use of interactive methods in CSE also shows promise in terms of improving academic outcomes overall, although more research is needed. The article highlights that although a significant number of national policies include CSE, large-scale implementation has occurred only in a small number of countries. It also highlights the very limited progress in reaching the most vulnerable young people, including younger (aged 10–14 years) adolescents.

The third article focuses on improving access to, and use of, SRH services by adolescents [30]. The article by Denno et al. presents a review of programs and strategies that have been effective in improving adolescents' access to, and use of, SRH services in low- and middle-income countries. The article found, notably, that youth centers are not an effective way to deliver SRH services. Successful programs in different contexts have implemented a package of interventions that include training and support of health workers; improving the youth-friendliness of the facility; building community support for health service provision to adolescents; and generating adolescent demand. Large-scale implementation of this package of interventions is only just beginning; this needs to be carefully documented and evaluated to identify elements of success and to determine the impact on the health of adolescents. The article also stresses that more research is needed to determine effective ways of providing this package of services outside the health facility setting and especially to marginalized or vulnerable adolescents.

The fourth review, by Lundgren and Amin, aims to identify effective approaches to prevent gender-based violence, in particular, intimate partner and sexual violence among adolescents [31]. Three promising approaches emerge from this review. First, school-based dating violence interventions show considerable success. However, they have only been evaluated in high-income countries and, hence, need to be adapted and evaluated in other settings. Second, community-based interventions to promote gender-equitable attitudes among boys and girls have shown promise in changing norms that condone violence but have not been evaluated or shown to impact the perpetration or victimization of violence. Third, evidence, primarily from high-income countries, suggests that parenting interventions are effective in preventing child maltreatment, which is a known risk factor for the victimization or perpetration of intimate partner violence and sexual violence later in life among adolescents and adults. The article highlights the significant gaps in evidence, particularly from low- and middle-income country settings and provides promising ideas for integrating the prevention of gender-based violence in work with parents of adolescents and in sexuality education interventions.

The final article, by Villa-Torres and Svanemyr, stresses that youth participation and leadership needs to be evaluated both as a process and as a program component [32]. Based on a review of literature, the article summarizes the evidence and presents youth participation models and frameworks, evaluation tools, and new methodologies. There is little evidence and consensus on the effectiveness of adolescent participation in health programs. The authors argue that participation is a right and should not be evaluated only in terms of health outcomes and impact. Efforts to pursue meaningful youth participation must be combined with efforts to assess whether they contribute to the success of programs. For this, evaluation methodologies need to be developed and rigorous evaluations must be carried out to assess both processes and outcomes and to suggest where changes need to be made. The article concludes that, although there has been a lot of investment in youth participation, more research and documentation, as well as the adoption of innovative practices for involving youth in SRH programs, are needed urgently.

The way forward: International Conference on Population and Development beyond 2014 and the post-2015 development agenda

In the 20 years since the ICPD, government bodies and nongovernmental organizations (NGOs) in many low- and middle-income countries have implemented ASRH programs and projects, often with support from international NGOs, multilateral/bilateral funding agencies, and private foundations. The articles in this volume illustrate that we have a slowly growing body of evidence about effective interventions and promising approaches.

Taken together, these five articles provide a rich but still insufficient mix of promising ideas and effective approaches for improving ASRHR. Several interesting themes emerge. First, the provision of sexuality education and SRH services should be closely linked, and the delivery of this package should be combined with efforts to build awareness and acceptance for their provision among adult gatekeepers—parents, teachers, religious leaders, political leaders, and so forth. In the absence of a supportive environment, these interventions can neither be delivered nor can they be taken up by adolescents. Second, for the provision of youth-friendly SRH education and services, and the building of supportive environments to occur at scale and in a sustained manner, actions are needed by different sectors at different levels—individual, couple, family, community, and society. Where this is happening, there are mechanisms that allow different players to make complementary contributions. Third, a clear message is that addressing gender inequality—in terms of beliefs, attitudes, and norms and promotion of more equitable power relations—leads to improved health behavior and health

outcomes. Hence, interventions to promote gender-equitable norms and power relationships as well as human rights need to be central to all future programming and policies. Finally, several articles highlight the importance of interventions targeting the early adolescent period (10–14 years). Policies and programs are addressing older adolescents and young adults but are leaving out younger adolescents (i.e., 10- to 14-year-olds) either deliberately or inadvertently. We need to reach young adolescents because a substantive proportion of this group is already sexually active; some of them experience problems resulting from early and unprotected sexual activity. More importantly, attitudes and values related to gender equality, sexuality, and health behaviors are established in this period and have important implications for health and social well-being in later life.

An overall observation is that many of the programs and projects aiming to improve ASRHR were often small in scale and short lived. They were also generally poorly monitored, evaluated, and documented. International NGOs and universities carried out a number of research studies and evaluations, but only a small proportion of these were aimed at developing and testing interventions to improve ASRHR. Although we now have a better understanding of the needs and problems of adolescents, what works and also what does not work, there are also many gaps in our knowledge and understanding.

The reviews point to a number of challenges to be addressed and questions to be answered. First, activities to promote young people's participation in SRH interventions have not been evaluated adequately. We need more investment in enabling the participation of young people in programs and in evaluations to assess its benefits. However, despite the lack of evidence, the importance of youth participation is a core value and principle in and of itself. Second, we have little knowledge about the optimal level of intensity and duration of efforts to bring about sustained behavior change. Many interventions are limited by a focus on attitudinal change, which does not always translate into behavior change. A few illustrate impact on behavior change immediately after the intervention, but it is unclear whether these changes would have been sustained over time. Third, we need to learn about how to take effective interventions or demonstration projects to scale without compromising their quality. Fourth, although the importance of reaching marginalized groups of adolescents (e.g., because of ethnicity, sexual orientation, conflict, out of school) has been acknowledged, most interventions have failed to reach them. We need to learn how to reach and involve them because they are more likely to experience health and social problems and are less likely to enjoy family and community support and access health and counseling services. Finally, new technologies such as digital media and mobile phones offer enormous opportunities for reaching and engaging adolescents with SRH information and services. However, there is limited understanding of how adolescents are already using and engaging with new technologies to learn and communicate with their peers or trusted adults about sexuality and SRH.

The lessons learned from the articles in this volume are critical in guiding future programs and policies. Considerable progress has been made since ICPD 1994 on a range of SRH indicators. Young peoples' rights have advanced. We need to build on these achievements to move forward. The many knowledge gaps, however, point to the pressing need for further research on how to best to design effective adolescent SRH intervention packages and to deliver them. The volume also highlights that support for the ICPD vision of meeting the "the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality" (para. 7.3) is not universal. Ensuring the SRH of adolescents is an unfinished agenda of the ICPD PoA, and all stakeholders need to strengthen their commitment and efforts for the world to move further toward its goals.

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